APPLICATION FOR REGISTRATION
TO OPERATE AN OUT OF STATE MOBILE HEALTH CARE ENTITY

State Form 53398 (8-07)
INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF ACUTE CARE

Division of Acute Care Use Only

Date Received_____ *(month/day/year)*

Date Approved_____ *(month/day/year)*

- ***All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached. AN INCOMPLETE OR ILLEGIBLE APPLICATION WILL BE RETURNED WITHOUT BEING PROCESSED.***
- ***Registration and/or approval renewal must be obtained annually.***
- ***This application and the registration, and/or approval which may be issued as a result, are neither assignable nor transferable.***

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Agency** ☐ **Renewal**

Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Out of State Mobile Health Care Entity Parent Location *(name of agency d/b/a of direct owner))*

If the d/b/a name is different from the direct owner submit a "Certificate of Doing Business Name" document from the Indiana Secretary of State *that lists the direct owner and "doing business as" (d/b/a) name.*

Name of agency							
Street address *(number and street)*						P.O. Box	
City		County				ZIP Code +4	
Telephone number ( )	Fax number ( )	Agency's office hours *(i.e. 8:00 a.m. – 4:00 p.m.)*					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
E-mail address		Web address					

B. Mailing Address *(if different from practice location)*

Street address *(number and street)*		P.O. Box
City	State	ZIP Code +4

C. Ownership Information *(direct owner of the agency d/b/a)*

The owner as registered with the Indiana Secretary of State and appears on the Articles of Incorporation, Certificate of Incorporation or Certificate of Organization, Certificate of Assumed Business Name, etc.

Owner of the agency		
Street address *(number and street)*		P.O. Box
City	State	ZIP Code+4
Telephone number ( )	Fax number ( )	
EIN Number *(submit documentation to validate)*		Fiscal year end date *(mm/dd)*

D. States, foreign countries or provinces entity is registered or licensed in. Provide copy of each state/country/province registration or license *(IC 16-41-42-1)*

E. Name of company(s) affiliated with Out of State Mobile Health Care Entity *(IC 16-41-42-5)*

Name	Address *(street address/city/ZIP Code)*	Telephone Number

SECTION III – STAFFING

A. Employees currently in good standing licensed, certified, or registered in a health care profession in Indiana or any other state. Provide copy of employee's license, certification or registration. (*IC16-41-42-5*)

Last Name	First Name	Initial

B. Health Care services to be provided under a contract *(IC 16-41-42-5)* **Provide copy of contract and license/certification/registration.**

Last Name	First Name	Initial

C. Health care services, health care tests and equipment that the health care entity will perform or use. *(IC 16-41-42-5(4))*

Health Care Service performed	Health Care Tests performed	Equipment used

D. Describe the manner in which test results and recommendations for health care based on the results are disclosed to the patient. *(IC 16-41-42-5)* **Provide copy of a sample report.**

SECTON IV - OWNERSHIP

A. Type of Ownership ***(applicable for change of ownership only – do not complete if initial application)***

☐ Asset Purchase Agreement ☐ Assignment of Interest ☐ Lease
☐ Merger ☐ New Partnership ☐ Sale
☐ Termination of Lease ☐ Transfer of Asset Agreement ☐ Other _____

Submit a bill of sale or comparable document, which includes corporation/owner(s) name(s) and buyer/seller signature(s) and effective date of transaction with the application.

B. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Federal
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Other *(specify)* _____

Submit applicable document from the Indiana Secretary of State

- If a Limited Partnership, submit a copy of the "Application for Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.
- If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State.
- If applicant is out of state corporation (foreign corporation), submit a copy of the "Certificate of Authority" to do business in the State of Indiana signed by the Indiana Secretary of State.
- If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.
- If the "doing business as" (d/b/a) name is different from the corporation's direct owner's name submit "Certificate of Assumed Business Name" signed by the Indiana Secretary of State.

SECTION V - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a registration to operate a Mobile Health Care Entity in the State of Indiana, and in support of this application, represents and shows that the owners and operators are of reputable and responsible character, are able to comply with IC 16-41-42, and will operate and maintain this entity in accordance with those requirements.

I hereby certify that the operational policies of the entity will not provide for discrimination based upon race, color, creed or national origin.

I swear or affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws and rules governing the regulation of Mobile Health Care Entities in Indiana.

President/Chairperson/CEO) *(typed)*	
Signature of President/Chairperson/CEO)	Date of Signature *(month, day, year)*
Mobile Medical Unit Manager *(typed)*	
Signature of Mobile Medical Unit Manager	Date of Signature *(month, day, year)*

SECTION VI - REQUIRED DOCUMENTS TO BE SUBMITTED WITH REGISTRATION APPLICATION

Submit the documentation as defined in IC 16-41-42.

Documents from the Indiana Secretary of State (*submit applicable documentation):*

(a) If a limited Partnership, submit a copy of the "Application for Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.
(b) If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State.
(c) If applicant is an out of state corporation (foreign corporation), submit a copy of the "Certificate of Authority" to do business in the State of Indiana signed by the Indiana Secretary of State.
(d) If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.
(e) If the "doing business as" (dba) name is different from the corporation's (direct owner) name submit "Certificate of Assumed Business Name" or "Articles of Incorporation" that list the owner and d/b/a name signed by the Indiana Secretary of State.
(f) Submit a SS-4 or comparable document from the Internal Revenue Service that reflects direct owner's name, d/b/a if applicable and EIN number or social security number.

Return the application and required documentation to:

Indiana State Department of Health
Acute Care Division 4A-07
2 N. Meridian St.
Indianapolis, Indiana 46204